RYAN WHITE HIV/AIDS TREATMENT EXTENSION ACT
SPECIALTY POOLS AUTHORIZATION REQUEST

All information must be completed and the form signed by both consumer and provider prior to authorization.
Fax completed requests to (619) 718-9870 . For assistance, call (619) 542-4308.

Consumer _____ **Date of Birth** _____ **SSN** _____
Last Name First Name MI

Gender: ☐Male ☐Female ☐Transgender **Mother's Maiden Name** _____

Address _____ **Phone** _____

I, the above-named consumer, consent to the release of personal and medical information, including my HIV/AIDS status, to the Council of Community Clinics, designated specialty providers and other agencies as required to verify my eligibility for Ryan White HIV/AIDS Treatment Extension Act services.

Consumer's Signature _____ **Date** _____

SPECIALTY PROGRAM POOL: ☐ **Medical** ☐ **Home Health & Hospice**

REQUESTED SERVICE(S)

Medical Pool requests **must** include the CPT code(s); **Home Health & Hospice Pool** requests **must** specify the number of visits or hours by type of service.

CPT/CDT Code	Description	Authorization Number* (CCC Use Only)

*Authorization Numbers expire 90 days after the approval date. EXPIRATION DATE: _____

Working diagnosis for request: (ICD-9 Code/s) _____

Is this request HIV-related? ☐ Definitely ☐ Possibly* ☐ Not related

What is the urgency for this service? ☐ Today ☐ Within 1 week ☐ Within 2 weeks ☐ Within 3-12 weeks* ☐ Later*

For requests that are 'Possibly' HIV-related or the urgency is greater than 2 weeks:

Has this request been approved by the requesting clinic's Utilization Review Committee? ☐ Yes ☐ No

Reviewer_____ Date_____

Explanation of relation to HIV _____

_____

_____

Specialty Provider_____ **Phone** _____ **Fax**_____

Address _____

Referring Primary Clinic _____ **Referring Physician** _____

Address_____ Phone_____ Fax_____

I confirm that I have verified that the above named patient is eligible to receive services under the Ryan White Primary Care Program.

Signature of Clinic Staff Completing Form_____ **Print Name & Title**_____

AUTHORIZATION STATUS ☐ Approved ☐ Denied ☐ 1 ☐ 2 ☐ 3

Date _____ **Time** _____ **Staff** _____

Council of Community Clinics…P.O. Box 880969…San Diego, CA 92168-0969

(RWTEA 12/17/09) **Submit Claim within 60 days of date of service to this address.**